Wisconsin Health Insurance Risk Sharing Plan (HIRSP)
Division of Health Care Financing
Department of Health and Family Services
6406 Bridge Road, Suite 18 • Madison, WI 53784-0018
Customer Service: (800) 828-4777 or (608) 221-4551
Fax: (608) 226-8770

HIRSP instructions for completing the Confidential Information Release Authorization form

Attached to these instructions is the Confidential Information Release Authorization form, also known as the HFS-9 form. You will need to complete this form if you wish to authorize HIRSP to communicate with another individual (including your spouse, another family member, or an insurance agent) regarding your personal health information, including premium billing or claims billing. When completing the form, please note the following:

Person Whose Records Will be Released
Complete the entire section.

Name and Address – Agency/Organization
This field is pre-filled with the HIRSP address. Do not fill this element with a different address.

Information May be Released to
Complete the entire section.

Specific Description of Records Authorized for Release
This field is pre-filled with several types of records that may be released to the individual you have named. Circle each record type for which you are authorizing release, or circle all of them to authorize the release of all records. If the record type desired is not listed, enter this information under "Other."

Purpose or Need for Release of Information
Explain why you are authorizing the release of the records specified above; be specific.

Authorization Expiration Date
Near the bottom of the page, three authorization expiration options are listed under "Choose One." An expiration date **must** be entered if one of the first two options is checked; if the third option is checked, an action or event must be entered.

Signatures
To authorize the release of your personal information, you must sign the form under Signature – Person Whose Records Will be Released. If another person is legally authorized to give release consent for you, this person must sign under Signature – Other Person Legally Authorized to Consent to Disclosure and must submit documentation verifying that he or she has legal authority to act on your behalf.

Mailing Instructions
When you have completed the form, send it to:

Wisconsin HIRSP (Customer Service)
6406 Bridge Rd Ste 18
Madison WI 53784-0018

DEPARTMENT OF HEALTH AND FAMILY SERVICES
HFS-9 (Rev. 04/03)

STATE OF WISCONSIN
Sections 19.35 & 19.36, Wis. Stats.

CONFIDENTIAL INFORMATION RELEASE AUTHORIZATION

Completion of this form authorizes the release of information described in the section below called "Specific Description of Records Authorized for Release". The person (record subject) whose records are released may have a right to inspect and, upon paying any applicable fees, obtain a copy of the disclosed records. Except for medication / somatic treatment records, a director/designee of a treatment facility for mental illness, developmental disability, alcohol or drug abuse may deny that right during treatment in some circumstances. Section 51.30, Wis. Stats., HFS 92.03-92.06 Wis. Adm. Code.

Name – **Person Whose Records Will be Released (Record Subject)**

Address

City, State, Zip Code

Identifying Number (If Any) | Date of Birth

Name and Address – **Agency / Organization I Authorize to Release Information**

Wisconsin HIRSP (Customer Service)

6406 Bridge Rd. Suite # 18

Madison, WI 53784-0018

Name - **Information May be Released To**

Organization

Address

City, State, Zip Code

Specific Description of Records Authorized for Release (Include dates of records, if applicable)

Please circle what you would like to release:

Eligiblity (Covered Period)
Claims payment & denial (both Medical and pharmacy)
Services provided
Deductible and co-insurance
Other:

Subsidy
Premium
Application Status
Requested Underwriting Information

Purpose or Need for Release of Information (Be Specific)

Understandings

- This authorization is voluntary. Refusal to sign will not affect treatment, payment, enrollment or benefits eligibility except for:
  ☐ No exceptions ☐ Exceptions (specify):
- The information that I authorize to be released may be redisclosed by the recipient of the records only if allowed by law. If information is redisclosed, the recipient of the redisclosed information may be controlled by different laws.
- I may revoke this authorization, in writing, at any time except for information already released as a result of this authorization. The written revocation must be given to the agency/organization I authorized to release information.
- Unless revoked, this authorization will remain in effect until the expiration time indicated below.

Choose One:

☐ Authorization expires as of (Date).

☐ Authorization expires month(s) from the date I sign this authorization.

☐ Authorization expires after the following action takes place:

As evidenced by my signature, I hereby authorize disclosure of records to the person(s) or agency(s) specified above.

SIGNATURE - Person Whose Records Will be Released (Record Subject) | Date Signed

SIGNATURE - Other Person Legally Authorized to Consent to Disclosure | Title or Relationship to Record Subject | Date Signed